STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD HEALTHCARE CENTER	2400 COLLEGE AVE GOSHEN, IN 46526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00195394. Complaint IN00195394 - Substantiated. Federal/State deficiencies are cited at F157 and F282. Survey dates: March 29 and 30, 2016. Facility number: 000091 Provider number: 155689 AIM number: 100290080 Census bed type: SNF: 7 SNF/NF: 164 Total: 171 Census payor type: Medicare: 8 Medicaid: 126 Other: 37 Total: 171 Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review competed by 14454 on	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	April 5, 2016.			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure a physician's	F 0157	Please accept this Plan of Correction as our facility's Credible Allegation of compliance	04/06/2016

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	order was clarified timely for one of three residents reviewed who was in need of a clarification for an admission medication order. (Resident B) Finding includes: On 3/29/16 at 1:30 P.M., the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 2/14/16. Diagnoses included but were not limited to, atherosclerotic heart disease of native coronary artery with unspecified angina pectoris, transient cerebral ischemic attack, unspecified, and vertebro-basilar artery syndrome. A (name of local hospital) admission order, dated 2/14/16 at 9:25 A.M., indicated " Ranolazine [Ranexa - an antianginal medication] 1,000 MG [milligram] tab [tablet] er [extended release] 12h [hour] Dose: 1,000 Milligram Oral Daily At Bedtime...." Resident B's March 2016 Medication Administration Record (MAR), indicated the first dosage of Ranexa 1000 mg at bedtime was not documented as administered between the dates of 2/14/16 and 2/18/16. The nursing progress notes, dated 2/14/16 through 2/25/16, lacked any		for our Recertification and State Licensure Survey concluded on March 30, 2016. Submission of this Plan of Correction is not an admission by Courtyard Healthcare Centerthat the deficiencies alleged in the survey are accurate or that they depict the quality of nursing care and services provided to the residents of our facility. This plan of correction is being submitted solely because doing so is required by state and federal law. Considering the volume, scope, and severity of the alleged deficient practices noted in the CMS-2567, Courtyard Healthcare Center respectfully requests a desk review for this survey. If approved, we would be willing to provide any and all documentation requested including, but not limited to: education records, policies and procedures, check lists, and forms that have been completed, revised or implemented as part of this plan of correction. **F 157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM,ETC)** This facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental,	

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	documentation related to the notification of the on call doctor, the primary physician for Resident B or any new physician orders related to the administration of Renexa at bedtime. During an interview conducted with LPN (Licensed Practical Nurse) #1 on 3/30/16 at 9:30 A.M., LPN #1 indicated she was the nurse who was working with Resident B at the time of his admission to the facility. She indicated when she reviewed Resident B's admission orders she noted that he had not received the Ranexa 1000 mg dose at bedtime while in the hospital and she thought this was a new medication for him and at such a high dose she questioned whether or not the medication should be administered. LPN #1 indicated the on call doctor was contacted for clarification orders on 2/14/16 but the doctor did not clarify the order and indicated Resident B's primary physician should have been contacted to clarify the order. LPN#1 indicated Resident B's primary physician was contacted on 2/15/16 with no response. LPN #1 indicated she did not document the notification of the on call physician or the attempt to contact the primary care physician in the medical record she documented her attempts on the 24 hour report sheet. LPN#1 indicated she did not know if any further attempts to		or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment);or a decision to transfer or discharge the resident from the facility. This facility will also promptly notify the resident and the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in 483.15(e)(2);or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility will record and periodically update the address and phone number of the resident's legal representative or interested family member. **Corrective Action:** Resident B no longer resides at this facility. **How others are identified:** All residents have the potential to be affected bythis alleged deficient practice. **PreventativeMeasures**: Licensed nurses were educated on notification of changes related to new admissions/readmissions and clarification of orders with the attending physician. An additional section was built into our admission assessment to	

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	contact Resident B's primary physician were made. On 3/30/16 at 9:45 A.M., the 24 hour report sheets, dated 2/14/16 and 2/15/16, were reviewed. Each sheet indicated the physician had been notified related to a need to clarify the Renexa 1000 mg order but did not indicate any instruction by the physician related to the administration of the medication while waiting for clarification from the primary physician. On 3/30/16 at 10:55 A.M., an interview was conducted with the Director of Nurses (DON). The DON indicated that she had reviewed Resident B's clinical record and did not find any documentation of the on call doctors or the primary care physicians notification in the clinical record. She indicated that the resident's primary care physician gave instruction on 2/19/16 for the administration of Renexa 1000 mg at bedtime but that it was not documented in the nurses notes it was written as a physicians order. She further indicated she did not know if any further attempts to notify the resident's primary physician were made between 2/15/16 and 2/19/16 but that in the past it takes this particular doctor a long time to respond to facility communication and that her expectation would be that if an order needed to be		provide our nurses the opportunity to document the information. **Monitoring:** The Director of Nursing/Designee will monitor admission/readmission documentation for physician notification and medication clarification on incoming residents. This audit will continue for 6 months. Results of this audit will be presented to QAPI for need for further monitoring. **Dateof Completion:** April 6, 2016.	

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	clarified a order would be obtained to either hold or discontinue the medication until a clarification order could be obtained. On 3/30/16 at 8:45 A.M., the DON provided the current policy, "Medication Orders," effective date January 2007. The policy indicated "...Procedures...B. Any dose or order that appears inappropriate considering the resident's age, condition, allergies, or diagnosis is verified with the attending physician...." This Federal tag relates to Complaint IN 00195394. 3.1-5(a)(1)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure the plan of	F 0282	Please accept this Plan of Correction as our facility's Credible Allegation of compliance	04/06/2016

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	care was followed for a resident who was to receive a prescribed medication for one of three residents reviewed. (Resident B) Finding includes: On 3/29/16 at 1:30 P.M., the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 2/14/16. Diagnoses included but were not limited to, atherosclerotic heart disease of native coronary artery with unspecified angina pectoris, transient cerebral ischemic attack, unspecified, and vertebro-basilar artery syndrome. A [name of local hospital] admission order, dated 2/14/16 at 9:25 A.M., indicated " Ranolazine [Ranexa, an antianginal medication] 1,000 MG [milligram] tab [tablet] er [extended release] 12h [hour] Dose: 1,000 Milligram Oral Daily At Bedtime...." Resident B's March 2016 Medication Administration Record (MAR), indicated the first dosage of Ranexa 1000 mg at bedtime was not documented as administered between the dates of 2/14/16 and 2/18/16. The nursing progress notes, dated 2/14/16 through 2/25/16, lacked any		for our Recertification and State Licensure Survey concluded onMarch 30, 2016. Submission of this Plan of Correction is not an admission by Courtyard Healthcare Center that the deficiencies alleged in the survey are accurate or that they depict the quality of nursing care and services provided to the residents of our facility. This plan of correction is being submitted solely because doing so is required by state and federal law. Considering the volume, scope, and severity of the alleged deficient practices noted in theCMS-2567, Courtyard Healthcare Center respectfully requests a desk review for this survey. If approved, we would be willing to provide any and all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised or implemented as part of this plan of correction **F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** Services provided or arranged by this facility will be provided by qualified persons in accordance with each resident's written plan of care. **Corrective Action:** Resident B no longer resides at this facility. **How others are identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures**:	

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